VOL. 14, NO. 3 SEPT.-OCT., 1964

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The Center is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Department of Mental Health. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay if the patient is able to pay.

Butner Treatment Methods

Treatment at the Center is by psychotherapy and consists of group discussions led by the professional staff, educational films, individual consultations with staff members, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the medical director, one other physician, a psychiatric social worker, psychologist, chaplain and admitting officer, vocational rehabilitation counselor, activities director, and a full attendant staff.

The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment in response to written or telephone request to the Medical Director of the Center, 406 Central Avenue, Butner, N. C., expressing voluntary desire for treatment. All appointments must be confirmed by mail and should preferably be made by the patient's physician or by other professional personnel in the patient's community, for example, alcoholism information center personnel.

2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Service Agency, and a complete medical history,

compiled by the patient's family physician, are necessary.

3. A fee of $75, in cash or certified check, must be paid upon admission if the patient is able.

4. Sign a letter-statement requesting voluntary admission at the time of admission.

It is especially important that patients applying for admission have a thorough medical examination and be in good physical condition at the time of their admission. The Center is not a hospital or a sobering up facility and patients desiring admission should have been sober for at least seventy-two hours and should not be exhibiting withdrawal symptoms. There are no facilities provided at the Center for the treatment of physical illness. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Admitting Hours

Wednesday, Thursday and Friday during the morning and afternoon. Patients may have visitors after they've been at the Center for 2 weeks. Visiting hours are from 1:00-4:00 P.M. on Saturday and Sunday.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA DEPARTMENT OF MENTAL HEALTH

NORBERT L. KELLY, Ph.D.
Associate Director

NORMAN DESROSIERS, M.D.
Medical Director

GEORGE H. ADAMS
Educational Director

INVENTORY

VOLUME 14 NUMBER 3

SEPTEMBER-OCTOBER, 1964

RALEIGH, N. C.

An educational Journal on Alcohol and Alcoholism. Published bi-monthly by the North Carolina Alcoholic Rehabilitation Program created within the State Hospitals Board of Control by Chapter 1206, 1949 General Session Laws authorizing the State Board of Health and the Department of Public Welfare to act in an advisory capacity. Offices 2100 Hillsboro St., Raleigh, North Carolina.

LILLIAN PIKE
Editor

JACKIE RANSDELL
Assistant Editor

ELEANOR BROOKS
Circulation Manager

Statement of Ownership, Management and Circulation

Inventory is published bi-monthly by N. C. Alcoholic Rehabilitation Program at Raleigh, N. C. Mrs. Lillian Pike is editor. Inventory is owned by N. C. Alcoholic Rehabilitation Program and sent free of charge to those requesting it. 21,716 copies of the July-August, 1964 issue were mailed to readers. The average number of copies of each issue distributed during the past 12 months was 21,213.

Write: INVENTORY, P. O. Box 9494, Raleigh, North Carolina.

ENTERED AS SECOND-CLASS MATTER AT THE POST OFFICE, RALEIGH, N. C.
UNDER THE AUTHORITY OF THE ACT OF AUGUST 24, 1912

Perfection and the Alcoholic

BY HERMAN E. KRIMMEL

DIRECTOR
CLEVELAND CENTER ON ALCOHOLISM
CLEVELAND, OHIO

The setting of unrealistic goals by the alcoholic in an effort to prove himself can become a barrier to effective treatment.

MANY alcoholics are perfectionists. This may sound paradoxical to anyone who has witnessed the alcoholic in drunken episodes of stumbling blindly upstairs, lurching through the house and knocking over the furniture, creating chaos at social affairs, or behaving at the dinner table in a way that would offend any self-respecting glutton.

These transgressions committed while intoxicated may account for the insistence on perfection when sober. The harassing guilt that follows outrageous behavior demands atonement and the alcoholic may feel that he can achieve this only by flawless performance. Since this goal is unrealistic, it can become a barrier to effective treatment. If he doesn't attain perfection—and, of course, he cannot—he may simply surrender to the inevitable and go on another bender to forget.

An illustration encountered in almost any outpatient clinic is related to payment of bills. Recently, the mother of an alcoholic told us that her married son had, after a few months of sobriety, returned to his daily fifth. He displayed remorse during occasional sober hours and said he wanted help. Unfortunately, he owed the clinic one hundred dollars and, he declared loudly and righteously, he did not intend to endure the humiliation of facing the staff until his debt had been completely paid. He spurned the family physician on the same pretext.

The suggestion that this man might pay his bills on the installment plan was angrily rejected. It had to be all or nothing. Since he had no money, it was nothing. This did not discourage his continued performance of sound and fury in a pathetic effort to persuade those around him that he was better than other people because of his impeccable virtue in financial matters.

Obviously, this was irrational posturing but it is a device that many alcoholics use to keep going by self-deception.

Alcoholics frequently demand perfection in others that they cannot find themselves. A man will build inconsequential flaws in his wife into unforgivable character defects. If she fails to compulsively clean the ash trays, he denounces her as an intolerably, sloppy housekeeper. If she is unable to serve expensive roasts and, at the same time, save money on his erratic and inadequate earnings, he damns her as a spendthrift.

All too often children are victims of this displaced drive for perfection because of some imagined reflection on parental abilities. He may rant and storm at the child who takes music lessons but

Reprinted by permission from *The News*, published by the Cleveland Center on Alcoholism.

falls short of the excellence of Heifetz or Horowitz. He is crushed if his son, striving desperately to make the grade in Little League, fails to display the potential of Mays or Mantle. And, of course, he has only disdain for other parents whose children fail to meet his impossible standards.

Some alcoholics extend this demand for perfection to therapists, A. A. sponsors or almost anyone who tries to help them. They are quick to detect the slightest flaw and use this to avoid their own responsibilities in a relationship. They sometimes express this tendency by shopping for therapists or sponsor. They go from psychiatrists to social workers to psychologists to internists. They may attempt this same pattern with A.A. groups and A.A. sponsors. No one ever measures up to their requirements and compromise seems to be unthinkable.

The need to show the world that he is superman instead of a sot may compel the alcoholic to set unattainable goals for himself. Mr. W., for example, had been encouraged, as far back as grade school days, to believe that he was a genius. His I.Q., that unreliable measure of almost anything, was reported as being 170. A doting mother was naturally delighted and teachers beamed fondly. Through high school and college, as the boy grew into a man, he was convinced that he was, indeed, a genius. Apparently he also persuaded himself that he should accept only such employment as would fully utilize that titanic gift. However, if one decides to work exclusively at the genius level, job opportunities are limited so Mr. W. was almost continuously unemployed. His drinking became alcoholism and he finally sought clinical help.

The therapist recognized his superior intelligence but thought it missed the genius level by a wide margin. He decided to give the patient another intelligence test despite its limitations. This time the score was around 130. This seemed closer to reality. Also it enabled the therapist to point out to Mr. W. that he was highly intelligent but hardly a threat to the reputation of Leonardo DaVinci. The patient was persuaded to abandon the striving for Olympus and to seek employment at a realistic level. He eventually found a position as a school teacher and was quite successful.

This change was not accomplished easily or quickly. There were many facets in the therapy but the beginning was the need of the patient to see himself and his potential realistically. This meant the establishment of attainable goals and avoidance of the self-punishing despair that follows inevitable failure when one tries for the impossible.

The alcoholic, almost invariably the victim of a nagging sense of inadequacy, feels an overwhelming need to prove himself. He has to prove his masculinity, his ability, his independence. That may be the reason for his wrath when the use of a so-called "crutch" is offered as an adjunct to therapy. Some alcoholics reject the use of medication, especially Antabuse, because they do not want to become dependent. They insist that, above all, they have to help themselves, and "surrender" to medication is to them a sign of weakness.

This is, of course, fallacious. The immediate goal for any alcoholic is to stop drinking and any aid is justified if it does not impair his health or functioning. Sometimes it is possible to overcome this resistance by pointing out to the patient that most people effectively use "crutches" such as eyeglasses, hearing aids and dentures without loss of status.

The frantic striving to prove oneself combined with fear of consequences may be the force that impels some alcoholics to attempt to function under conditions that would defeat non-alcoholics. They may not be able to stop drinking by a simple act of will but they do not lack will power in other ways. Sometimes it seems as if they have more than their

(Continued on page 26)

Helpful in Group Therapy

After reading several of the issues of the *Inventory* periodicals, I have found that they are valuable to me in many of my group therapy sessions with alcoholic patients. I am a nursing supervisor working in an alcoholism treatment and research center located at Malcolm Bliss Mental Health Center in St. Louis, Missouri. The nursing team plays an important role in the treatment of patients suffering from alcoholism and much of the patients' treatment consists of education about their illness. Your publication is of value to us in many ways. Could you please add my name to your mailing list?

Mrs. Vonceal Poiner
St. Louis, Missouri

Works With Students

I have heard some impressive things concerning the work which all of you are doing and wish to add my congratulations and thanks. Would you please add my ame to your mailing list for *Inventory* and suggest any other material which you make available that might be of help to me as one working with students?

Pat Hall
Greensboro, N. C.

Article for Physicians

In a truly outstanding magazine your July-August issue stands out even more. I am sending my copy to my son who is an intern in Philadelphia, urging him to read Dr. Desrosiers' article on the "Philosophy and Practice of Alcoholism Treatment", as it seems to me so absolutely timely for anyone entering the medical field. I am urging beyond this, if he can possibly find the time, that he read the rest of the magazine, for it all should be beneficial to the career for which he is preparing himself. Thank you for letting me share the information and inspiration of your little magazine.

A. E. Agnew
Brigadier, Salvation Army
New York, N. Y.

Request From Al-Anon Group

Would it be possible for the Napier Al-Anon Family Group to be placed on your mailing list? We think your publication is excellent and have found several helpful articles in a few old ones we have been given.

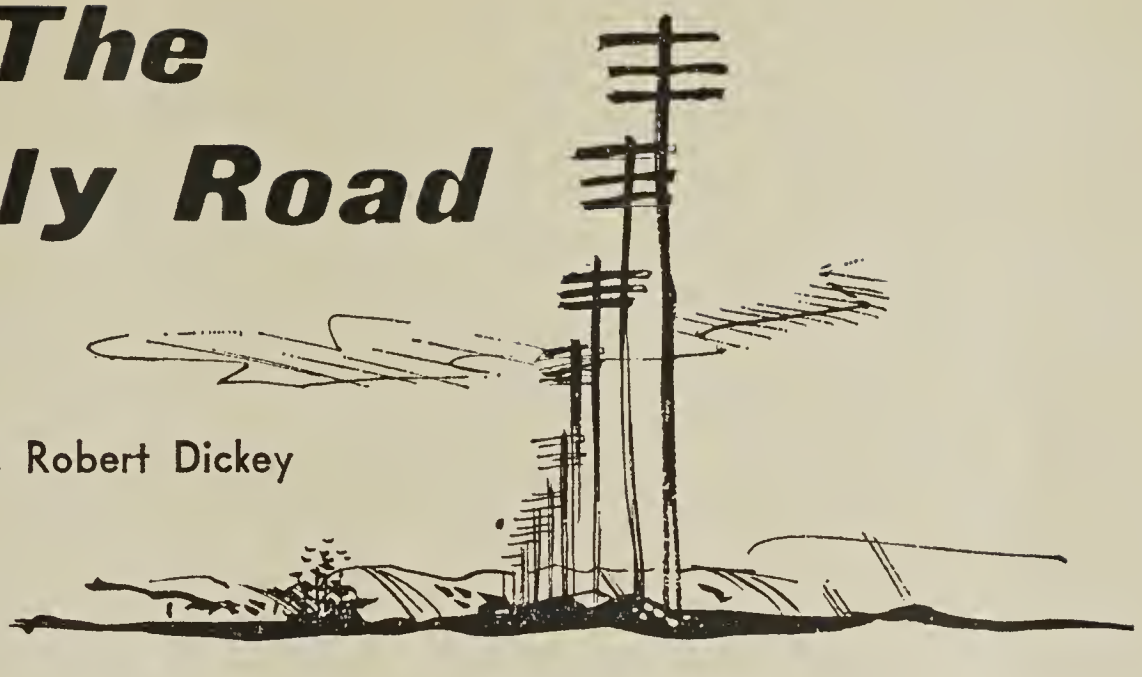
Anonymous
Hawke Bay,
New Zealand

Material For Nursing Students

In years past, we have found the literature you sent us for our class on "Alcoholism and the Role of the Nurse" most helpful and informative. We would appreciate your sending us any such free materials you have available. This year we will have twenty-five senior nursing students in the fall and a like number in the spring—a total of fifty for the school year. We appreciate very much the assistance you have already given us.

Diane G. Fogleman
Instructor, Psychiatric Nursing
N. C. Memorial Hospital
Chapel Hill, N. C.

The Lonely Road



By C. Robert Dickey

MEDICAL recognition of a disease or illness, generally speaking, requires that the illness have a characteristic train of symptoms and follow a reasonably predictable course. The species of alcoholism that is predominant in North America fulfills these requirements.

Most people who are in close contact with an active alcoholic are baffled by his behavior. They fail to realize that this is not an isolated case, but is typical of the vast majority of the estimated 5,000,000 alcoholics on this continent.

These symptoms of an authentic illness are most frequently thought to be the deliberate behavior of a deviant person whose illness (if indeed it is admitted to be an illness) is self-inflicted, deliberately and stubbornly pursued with a singleness of purpose that is utterly-incomprehensible to the observer. The alcoholic appears to flout the laws of God and man, to invite ignominy, and to court disaster. Some knowledge of the characteristics and phases of the illness, especially in the earlier stages, plus awareness of the pre-alcoholic symptoms that may be recognized, should prove useful.

One other factor that often militates against recognition of a developing problem is the still common tendency to identify "the alcoholic" with only the late-stage alcoholic. Family, friends, fellow workers, the problem drinker himself, all are reluctant to accept the label 'alcoholism' or 'alcoholic.' This is analogous to repudiating a diagnosis of tuberculosis unless the patient is far advanced, highly infectious, with cavities, and an almost hopeless prognosis.

It is a fact, however, that the majority of alcoholics in our Canadian society are in early or middle stages, and present a picture of relative stability, since their ailment is still largely hidden. Alcoholism lends itself to concealment, and often for many years the family, friends, and fellow employees cooperate to protect and 'cover up' for the alcoholic in the mistaken belief that they are

Alcoholism has a characteristic train of symptoms and follows a reasonably predictable course.

This article is reprinted by permission from the June, 1962 issue of *Progress,* a publication of the Alcoholism Foundation of Alberta. The author is information officer at the Foundation.

helping. Earlier recognition of warning signals by family or friends, or by the problem drinker himself, may prevent many years of mounting torture or untimely death.

In this paper we draw heavily on Dr. E. M. Jellinek's 'Phases of Alcohol Addiction in Males,' which is based on a comprehensive study of several thousand case histories of recovered alcoholics in AA. It should be pointed out that this is a 'composite picture' of the course of our predominant variety of alcoholism. This species has been called the 'bender' type. Not all alcoholics experience all of the symptoms, nor do they necessarily occur in the same order. Moreover, occasional symptoms mentioned here might be observed in any user of alcohol, with no special significance. However, a cluster of symptoms, three or four perhaps, occuring again and again, can be considered indicative of a problem, present or developing. (It may be noted that, though this study applies more especially to the 'bender' species of alcoholic, many of the symptoms here described apply also to the 'daily excessive' type of alcoholism.)

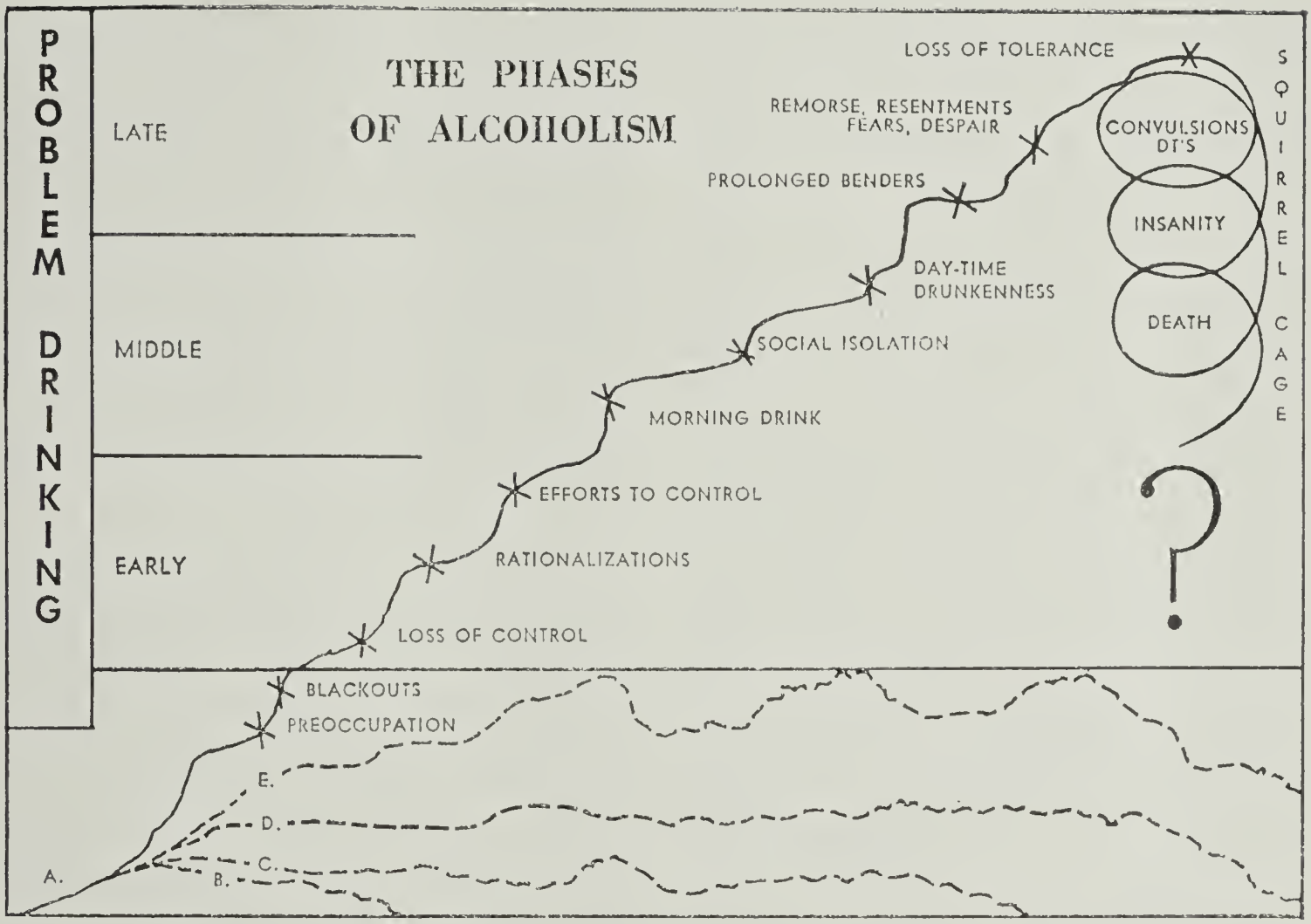
Since most alcoholics probably began as 'social drinkers,' Chart I shows a line commencing at the lower left corner, the first part of which represents the 'social drinking' common to all; from this four broken lines branch off. The solid line A represents the alcoholic. Lines B, C, D, and E represent various drinking patterns among users, from the one who drinks very little to the line E representing a person who drinks frequently, perhaps heavily, and at times approaches 'problem drinking.' However, he retains control and can cut down or stop at will without too much difficulty. At times his behavior resembles alcoholism, but 'loss of control' does not occur.

Line A represents the alcoholic. It also represents the progressive divergence from ordinary drinking custom; it illustrates the inevitability of the progression of problem drinking, and it may be taken to convey the 'increasing tolerance' which will be discussed a little later.

Alcoholism, like most other illnesses, may commence at almost any age, from early youth to old age. The 'social drinking' period, then, may be very short or it may last for many years. During this period the future alcoholic is indistinguishable from the vast majority of drinkers who never have any trouble with their drinking. So far, we have no way of recognizing in advance who will or will not become alcoholic.

Causes of alcoholism being still unknown, it cannot even be hypothesized just what process of change occurs, but at some point in the future alcoholic's life, his attitude and feelings about alcohol, his reactions to alcohol, his reasons for drinking, and his intake of alcohol begin to change, at first subtly and insidiously. Many authorities believe that this 'change' is a physical one, having to do with the metabolic system or the endocrine glands, but that in any case it is irreversible.

Reasons for drinking are, for most people who drink, quite similar, and the future alcoholic is no exception, at first. The alcoholic's changes in attitude are represented by line A on the chart, beginning at the part where line A begins to diverge. This may be called the "pre-alcoholic" phase. It will be agreed that probably everyone who drinks discovers the pampering effects of alcohol—its tension-reducing, anxiety-dissolving qualities, its ability to dull self-criticism and enhance self-acceptance. No doubt also, many who will never



have a drinking problem do occasionally and consciously make use of these qualities.

But the alcoholic-to-be begins to experience a more rewarding relief from drinking than was formerly the case, more satisfaction than is felt by other people. Occasional relief drinking becomes frequent, then continual. His tolerance for tension decreases as his use of alcohol to reduce tension increases. The pre-alcoholic phase may last from six months to several years.

Alcohol comes to occupy a more meaningful place in the future alcoholic's life. Several highly significant developments begin to occur almost simultaneously at the beginning of the phase which Dr. Jellinek calls 'prodromal.' This may be defined as preparatory or introductory. His physical tolerance for alcohol increases. This continues throughout the progression of the illness until well on into the late stages. This symptom is unfortunately mistaken by many people for a 'good' sign: that this person can 'take it,' or 'hold his liquor like a man.' Heavier drinking naturally follows, since he needs more to gain the same effects.

He develops a *preoccupation* with drinking and drinking situations. He seeks to repeat and prolong situations that have been enjoyable and satisfying because of the incidental drinking. He begins to think of social occasions in terms of this incidental drinking rather than of the social activity involved. He may by now have experienced his first blackout.

The blackout, or blank-out, is not to be confused with 'passing out.' It is partial or total amnesia for varying periods. There is no loss of consciousness, unless, of course, the drinker 'passes out' during it. Intoxication may or may not be apparent; in fact, when blackouts occur repeatedly, after medium intake and with no outward signs of intoxica-

tion, it is probably that true addiction is not far off, if not actually present. The blackout may or may not be sufficiently terrifying to make him realize his danger.

Throughout the prodromal phase, the preoccupation referred to manifests itself in any number of ways. There is a growing concern about supplies, about whether or not there will be enough to drink on this or that social occasion. This may prompt him to 'prime' before leaving, to take a mickey along, 'just in case,' or to sneak the odd drink. Surreptitious drinking becomes common procedure as his increasing tolerance makes greater consumption necessary in order to maintain the level of comfort he seeks. But he is also becoming aware that his drinking differs from that of other people, otherwise he would not feel the need to sneak drinks whenever possible. He will take doubles instead of singles, and gulp down the first one or two, for a 'quick glow,' and so that he may thereafter sip his drinks as others do. Already he is secretly concerned, feels guilty, and a bit ashamed of being 'different.' He will avoid references to his drinking; whereas he used to brag about how much he could drink, he begins to lie about how much he did drink. Blackouts may become more frequent and are experienced after smaller intake.

Marital relationships become strained during this phase. Humiliating scenes will not be uncommon, but the wife is eager to accept his expressions of sorrow and his promises to do better. She tries to convince herself that no real problem exists; she feels some concern but no alarm as yet. The prodromal phase may last from six months to five or six years.

Dr. Jellinek has placed the beginning of addiction at 'loss of control.' This is noted on the chart as the beginning of the early phase, or in Dr. Jellinek's terms, the 'crucial phase.' Many specialists believe that loss of control is merely another step in the process that began much earlier, in the prodromal phase, in fact. Dr. Jellinek has said '. . . it is feasible to intercept incipient alcohol addiction at this stage . . . It goes without saying that even at this stage the only possible modus for this type of drinker is total abstinence.'

The point is, that 'loss of control' does not occur overnight, and that the loss of control here applies only to quantity consumed, once started. At this point, and for a considerable time to come, the alcoholic can abstain for periods extending into months on end, but once having taken alcohol into his system, he has no longer any certainty that he will be able to stop at will. A characteristic of this type of alcoholic is that he gradually loses his power of choice, his ability to drink according to intention. With increasing frequency he over-shoots, drinking more than he intended to, getting drunk more often, and on more inappropriate occasions. The drinking becomes uncontrolled and uncontrollable once alcohol enters the system, but not on *all* occasions, not yet.

When this is happening three or four times out of every ten drinking occasions, and in the presence of other confirmatory symptoms, there is no longer any doubt about the diagnosis; addiction has set in. Willpower at this point is not in question. Any drinking of alcohol is apt to start a chain reaction which sets up an insistent need for more alcohol, and which increasingly results in more drinking. This has passed beyond the realm of conscious determination.

An outstanding symptom in the

early stage is the system of *rationalizations* which spreads progressively to every phase of the alcoholic's life. His drinking behavior is becoming more conspicuous, and is beginning to call forth reproof from his wife, perhaps from his employer. Friends become reluctant to accept his social invitations and to include him in their invitations, because he 'always makes a fool of himself.' His children, too, feel the social pressures, and withdraw from him because of his unpredictability.

Guilt and remorse haunt him increasingly, and he finds it necessary to construct an elaborate system of excuses and reasons for his heavy drinking. He is able to convince himself on each occasion that he had not in fact lost control, but had good reason to get drunk; that he can 'handle' liquor as well as anyone else, but who wouldn't get drunk under those circumstances? The rationalization system helps to counter the growing social pressures; it enables him to keep on drinking without complete loss of self-esteem, at least during this phase. He thinks that he is convincing other people with his rationalizations, but primarily they are desperately needed for his own reassurance.

His self-esteem, however, does suffer, and he must compensate, which he does partly through 'grandiose behavior,' tipping lavishly, ordering unnecessary taxicabs, making pointless long distance calls and the like. Another aspect of the rationalization system is the alcoholic's growing conviction that others are responsible for his problems, not he. Antisocial and aggressive behavior results. This again generates more guilt and more remorse, to be assuaged only by more drinking. The early phase may last from two to ten years.

As he nears the middle phase, he tries many methods to regain control, or rather as he sees it, to demonstrate that he has not lost control. He will 'swear off,' or 'go on the wagon' for certain periods. He will determine not to drink before a certain hour, or only at home, or set a limit to the number of drinks in a given period. He will switch from rye to scotch, scotch to wine, wine to beer, and so on. Each time he 'discovers' some new formula he will be convinced that he 'has it licked.' He fears that what his wife and (perhaps) his friends tell him is true, namely that he has no will power, and it becomes an obsession with him to prove how wrong they are. Rather than fearing that he will get drunk if he takes that first drink, he convinces himself that 'this time it will be different.'

Loss of Control Is Permanent

The alcoholic may, at some time during this period, consult his doctor, perhaps at the insistence of his wife, who fears that alcoholism may be developing, and has heard that it is a medical problem. Since the patient tends, of course, to minimize his drinking and the trouble it is causing, the doctor may assure him that he is not an alcoholic, but since he admits he is drinking too much, he should cut down. In other words, exercise conscious control. This is just what the patient wants to hear, but the prescription is impossible. Control is exactly what he has lost, and this is a permanent loss.

Varying degrees of pleasure usually attended his drinking during the pre-alcoholic and prodromal phases, and through a portion of the early phase. That period has been called 'pleasure drinking,' as distinguished from the 'sick drinking' that begins as he approaches the middle phase. When he begins to feel the need for

an 'eye-opener,' it is for medicinal purposes, to help him 'get along,' to 'start the day right,' to 'settle his nerves.' This need for a medicinal *drink in the morning* marks the beginning of the middle phase.

Most of us have heard that 'alcoholics drink in the morning.' Many problem drinkers are appalled at the mere thought of being an alcoholic, and for a long time they may resist the need for the eye-opener. Some will suffer excruciatingly for months, perhaps even years, rather than accept the label 'alcoholic.' But sooner or later it becomes impossible to start the day without a drink. For a while attempts are made to mask the telltale odor, with mints, strong mouthwash, breath-purifiers, and so on.

The earlier symptoms remain with the alcoholic; he takes them with him, so to speak, and they become intensified and more difficult to hide. His tolerance for alcohol continues to increase, requiring greater and more frequent consumption; he overshoots unintentionally more often, the blackouts continue, the efforts to control the drinking still seem feasible, and occasionally there is the appearance of a measure of success, but after each apparently successful period of abstinence or other control method, he returns to the old pattern, usually in a more pronounced manner. Remorse and resentments go hand in hand. Nobody 'understands' him.

The marital and home situation has been deteriorating. His wife has long since recognized the problem and has tried every method that has been tried by hundreds of thousands of other alcoholics' wives, with no success. She and the children suffer acutely, from *social isolation,* shame, and anxiety. She may order him out, or leave home with the children. If she returns, it will be to take over as head of the family. She will reorganize the (by now) disorganized home; the children no longer look to father for authority or love. They all are sure that 'if Daddy loved us, he wouldn't act this way.' His whole personality has been undergoing changes for the worse that are reflected in such comments as: 'he seems like a different person,' or 'he isn't the man I married.'

His hostility increases to the point where he anticipates rejection by friends whom he has humiliated or insulted, and he will drop friends who have tried to help him. He will anticipate discharge from his employment, quitting just before the fall of the axe. As his life becomes more and more alcohol-centered, the 'reasons' and excuses for drinking multiply; his concern becomes 'how his activities will interfere with drinking,' rather than how his drinking will interfere with his activities; and all outside interests suffer. He reinterprets all his interpersonal relationships in the light of his decreasing interest in anything but alcohol; his egocentricity leads to more isolation, more rationalizations and mounting self-pity. Many alcoholics at about this time try the 'geographic escape.' Having convinced themselves that it is all the fault of environment, or the job, or the home and family, they will try to make a new start somewhere else. Of course, this never has the desired result.

From the first eye-opener to occasional, then regular, morning drinks, then to several more in order to keep going, it is a short step to occasional *day-time drunkenness,* which will mark the period when the middle stage merges into the late stage. His resentments become more and more unreasonable. In the past it has not been too difficult to find

new jobs, but now jobs become harder to find and harder to keep. There seems to be a conspiracy directed toward 'keeping him down.'

The middle phase may last from two years to seven or eight. It is difficult to discern the beginning of the late phase, but he has certainly reached it when his *benders become prolonged,* where formerly they were for the most part confined to evenings and then long week-ends. It has been noted that the early stage has been called 'pleasure' drinking, and the middle stage 'sick drinking.' The late stage has been referred to as 'disaster drinking.' This it certainly is, but usually disaster, in a variety of forms, has already struck.

Obsessional Protecting of Supply

Protecting his supplies has been a major concern through many years, but now it becomes obsessional, senseless. He lays in large stocks of liquor and hides bottles in the most unheard-of places. A picture of the utmost in frustration is the man who has hidden a bottle on Saturday night in a blackout, who needs a drink desperately Sunday morning, but cannot remember where he has hidden the medicine.

Steadily increasing consumption of liquor has caused increasing neglect of proper nutrition, and many alcoholics suffer from this neglect. Hospitalization may now become necessary for any one of a variety of complaints caused or aggravated by nutritional deficiencies.

Throughout the early and middle phases most alcoholics exposed themselves, apparently willfully, to grave risks: loss of home, job, prestige, everything. Though this may seem paradoxical, they were at the same time exerting prodigious efforts to cling to some social footing and some self-respect. But by this time, rejection on all sides is so obvious that the alcoholic begins to believe that he is, in fact, without merit and without hope, though sporadically he may try for control. Ethically and morally he deteriorates; his thinking becomes impaired, even when not drunk. The personality changes mentioned earlier are by now pronounced and unmistakable.

He will become indifferent to the kind of alcoholic beverage he drinks, and may even have recourse to commercial products like rubbing alcohol, extracts, or aftershave lotion. He will drink with companions far below his social level, perhaps partly to recapture some feeling of acceptance or superiority.

His *alcohol tolerance,* which started to increase in the prodromal phase, now vanishes. To his dismay, he gets drunk on less than was formerly needed just to get a glow on. Anxiety has long been ever-present with him, but now it is a palpable thing. He 'feels everything closing in on him.' He is prey to nameless, indefinable fears, a sense of impending doom. He may hear voices, threatening, accusing, decrying him; he is filled with raging resentments and jealousies. Only one thing will give him some temporary relief from the torture of the 'squirrel-cage'; more alcohol and oblivion. He is sick from drinking; he drinks because he is sick; he drinks to ease or escape from the problems created by drinking.

Intolerable remorse and guilt are with him constantly; only liquor will ease the pain. Uncontrollable tremors beset him most of the time, but can be reduced by more liquor. He may have convulsions or 'rum fits.' Delirium tremens, an intense though transitory psychosis, may occur. More chronic psychoses may develop if the drinking continues.

(Continued on page 27)

I think it's time—time in history, and time in North Carolina in particular—to take more than a passing interest in the problem of alcoholism.

The size of this particular problem in North Carolina is staggering. I used to go around quoting a figure of roughly 52,000 people who are actually addictive drinkers, and when I say addictive drinkers, I mean people who *cannot stop drinking alcohol.* The other day, however, I was listening to Dr. Norbert Kelly, a sociologist and a most conservative person, who said, "Well, I think perhaps the *real* figure comes closer to 125,000 people."

I noticed in a little pamphlet that the New Hanover Council on Alcoholism put out on "Alcoholism as a Community Responsibility" that there are at least 1,400 alcoholics in this particular county. The pamphlet quotes another figure of 7,165 other people who are directly affected which, of course, is an extension of the initial figure by five times.

In North Carolina the people who are involved directly with the alcoholic inevitably include a spouse and at least two or three children, which means that the figure is not 125,000 but 600,000 people who are directly affected. This comes pretty close to being one-seventh of the population of the entire state.

When we think about some of the legal aspects of this problem, we are reminded that at least half of all automobile accidents which cause death and crippling in this state are partly, if not entirely, due and responsible to people driving under the influence of alcohol. And I don't have to remind you, as the federal director of prisons did in Raleigh not too long ago, that three-fourths of all crimes committed are committed

Alcohol — Man's Psychological Blessing and Physiological Curse

under the influence of alcohol.

There is also a tremendous economic facet to this business involving a large chunk of the American economy. The chunk is, in fact, so large that income from ABC sales in North Carolina alone for last year was 92 million dollars of which the state receives about 11 million in the form of revenue. This is the fifth consecutive year, for example, according to some of the reporting of the distillery industry, that there has been an increase—this year higher than ever before—in the consumption of alcoholic beverages. And the gallons of alcoholic beverages consumed amount to such a staggering figure that I can't even think in these terms, much less remember it.

This is a tremendous problem and as a physician it bothers me because I am interested in public health and I know unequivocably, having spent fifteen years working in a mental hospital and a few years now in an alcoholic treatment center, that alcoholism is only preceded as a major public health problem by cancer and heart disease. Alcoholism statistically is public health problem number four. I think it's number three. It is one of *the* major social problems this country has. It doesn't cry for solution; it screams for it!

We've been playing ostrich with the problem of alcoholism all along the line because of the ambivalence of the American attitude and American culture toward the use of alcoholic beverages. The game, of course, begins with the alcoholic himself. He denies that he is an alcoholic and he is able to deny it for such a long time that oftentimes he denies it right on up to the point where he's not capable of denying it anymore. The alcoholic's spouse is involved in denial as well, as we well know. And we are beginning to see that there are a lot more alcoholic females than we ever dreamed of. The ratio of male to female alcoholics is no longer five to one, not at the Center at least, because exactly six weeks ago the ratio there was two male alcoholics to every female alcoholic. The ratio has been dropping gradually and gradually—a rather shocking kind of discovery.

The spouse denies the fact that he or she has any contributing role.

The American Medical Association only recently recognized alcoholism as an illness.

Many hospitals, of course, are playing ostrich with the problem as well because they will not admit acute alcoholics as medical patients, which is a denial of the very reason for their existence.

I'm thoroughly convinced, after listening to the discussions of the legal authorities and police force

BY NORMAN A. DESROSIERS, M.D.

MEDICAL DIRECTOR
ALCOHOLIC REHABILITATION CENTER
BUTNER, N. C.

The psychological blessings of alcohol are bought only at the expense of nervous tissue in the brain and spinal and peripheral nerves.

Published by permission of the author, this article is based on a talk presented at the Third Institute on the Homeless Alcoholic of the North Carolina Flynn Christian Fellowship Houses, Inc. in Wilmington April 3, 1964.

people here today, that the law is totally perplexed with the problem of the revolving door alcoholic. And it is a tremendous problem, I know, because you have to deal with forty times as many alcoholics as I ever see. You deal with and treat, in a fashion, these alcoholics even though you realize full well that your "treatment" has its limitation. It is ineffective as many forms of treatment are.

And last, but not least, the state, up until the present time, has not accepted its full share of responsibility in the treatment of the illness. There are signs, however, that it is preparing to do so.

Despite the odds, and this sounds like crying sour grapes, I have to remind people again and again that alcoholism is a tremendous problem. Trained in philosophy, I worry about alcoholism from a sociologic standpoint. Trained in theology, I am bothered deeply by the moral issues coming out of it. As a physician, I shudder upon the close observation of the alcoholic.

Tonight, however, I am not going to talk about the alcoholic nor about the sociologic implications of alcoholism or even the economic implications which are tremendous. I am going to talk about alcohol—strictly as a scientist—in order to attempt to deepen your understanding of what you and I are up against.

In considering any illness, whether it be hookworm or tuberculosis, one has to consider three aspects of it: the agent, the thing that causes the illness when it gets into the host; the host; and the environment the infecting agent comes from. I believe alcoholism can be looked at in this particular way.

You have to consider that the agent in the disease of alcoholism—and when I get through I hope there won't be any doubts about the fact

Alcohol has been and i

that it is a disease, a chronic disease of a degenerative nature—is the exogenous substance, ethyl alcohol. The host, of course, is the pre-disposed individual. The environment is the socio-environmental culture with all of its attitudes toward this particularly socially approved behavior.

Now, for the rest of my time, I want you to look briefly at the agent, alcohol, through my eyes as a scientist because I want to consider and deepen your understanding of alcohol and how it affects any given individual who uses it.

On closely observing clinically many alcoholics, both in state mental hospitals over the last fifteen years and particularly at the Center over the last couple of years, I am disturbed and I do not like what I see. Science is honest and I like to think I am a part of that scientific discipline. As a researcher you have to look and observe, test and throw away, go back and look again, retest and throw away until you begin to see clearly what the truth is.

Alcohol has been mankind's psychological blessing from the beginning of its known existence. Now let me repeat that because this is something I think we forget when we are dealing with someone who becomes addicted to this inorganic, chemical substance. *Alcohol has been mankind's psychological blessing for centuries.* The adverse side of the coin is that *alcohol has been man's physiological curse for centuries.*

We begin our treatment program at the Center not in any moralistic way, but by trying to help the individual who comes to us to realize that *we understand what we are asking him to do.* Sometimes I think

that anyone involved in dealing with alcoholics—managers of Flynn Houses, people who run industry, personnel directors, physicians, psychiatrists, ministers, etc.—who say to the alcoholic, "If you take another drink, out you go," *don't* understand. I'm concerned not about the one or two who may make the grade, but about the many who get kicked out. They, too, are children of God whether we like it or not. And they may *need* to take that drink.

Now let me go on. We begin by teaching the psychological virtues of alcohol. Alcohol *does* have psychological virtues in a very positive way, and it has taken me a long time to come to see this. One thing I know, for example, is that alcohol and the use of it, despite the fact that an individual becomes addicted to it, does stave off developing psychosis—sometimes for years. This is nothing to be sneezed at because even the best of our antidepressant drugs do not stave off depression of profound degree. It takes drastic shock treatment to do that.

Now listen to this. You all know perfectly well that many people use alcohol every day. People use alcohol to relax at night before supper. They use it as an aperitif (the French are good at this), in order to stimulate the flow of gastric juice, to increase appetite. It is even good for reducing tension headaches.

You physicians will know that alcohol is a marvelous hypnotic. It enables an individual to relax and get off to sleep very nicely, although it's not natural sleep. It also reduces anger for it can facilitate the expression of angry feelings. It dissolves guilt very nicely. One psychological cliche is that alcohol is the best dissolver of the superego that is in existence today.

Alcohol makes some unlovable individuals more lovable, more compatible. It has been mankind's "fountain of youth." What male or female alcoholic has used alcohol and not been made to feel younger? None of them, of course. If you've talked to alcoholics at all, you'll see that they realize this.

It's good for dilating coronary arteries. It is one of the best medicaments for mildly tranquilizing an older person whose cerebral arteries need dilating. It's good for dilating coronary arteries, for example, as a coronary vasodilator in arteriosclerotic heart disease.

Alcohol has been the most available, readily obtainable, cheapest, most rapid acting tranquilizer and antidepressant that the world has ever known, as well as an analgesic, an anesthetic, a vasodilator and many, many, things. As one patient put it, "I haven't found anything yet that alcohol wasn't good for."

Alcohol has been and is and probably will continue to be the layman's panacea—and I use the word panacea advisedly because alcohol has such tremendous properties that it can *unquestionably* do all of these things psychologically and some physically. If you look at the facts as a scientist, not as a moralist, these things are true. You cannot deny them.

An individual who is predisposed to becoming addicted (or to becoming an alcoholic) learns the virtues of alcohol so well over such a long period of time that before he knows

(Continued on page 30)

PHARMACO
CARE

This article originally appeared in Volume 90 of the *Virginia Medical Monthly* and is reprinted here by permission of the editor. Dr. Ebbe Hoff, the author, is Medical Director of the Division of Alcohol Studies with the Virginia State Health Department.

ALCOHOLICS constitute a mixed group of ill people suffering from a complex of psychological, social and metabolic disturbances or maladaptations. Although the symptom of pathological use of alcohol is common to all of them, they exhibit varied patterns of drinking, loss of control and changes in tolerance. An important objective of therapeutic research and an essential requirement of successful therapy is to make a careful diagnostic study to categorize these patients according to the disturbances they exhibit and the patterns of their alcoholism so as to provide data for exploring etiological factors and planning therapy. A problem still facing the therapist stems from his inability to plan therapy based upon a confident theory of causation. An initial task in the care of the alcoholic is to bring the patient to therapy and help him to continue in a program of rehabilitation. This is often fraught with difficulty, particularly because alcoholism overtakes its victims subtly and often imperceptibly. Without understanding the reason, the alcoholic may find himself involved in the symptoms of uncontrolled and harmful alcohol use. It is not surprising, therefore, that he frequently resorts to rationalizations and denial of the reality of his problems. Even when denial is no longer possible, he may misinterpret his symptoms and misconstrue his course of action. He may seek to control alcohol use by enforcement of self-discipline and may use help from others only for recovery from the pangs of a drinking binge.

Nevertheless, public attitudes are gradually changing and a climate of opinion is developing which permits a larger and larger number of alcoholics to accept their condition and seek help voluntarily for themselves and for their family. The alcoholic is a sick person usually living in a family setting which is also disturbed. Some members of the family may be actually more sick than the alcoholic himself, either because of or from causes prior to the patient's alcoholism. The patient's progress in recovery may also create new disturbances in the family because of necessary changes in family interpersonal relationships. Thus, a recovering alcoholic may not be an acceptable partner to a spouse with a need to dominate and control. Family members have to learn to understand the nature of the patient's illness and their own problems so that there may be created an environment within the family that is therapeutic to all.

Many general practitioners as well as nonpsychiatric specialists have found that the care of alcoholics and their families can be quite successful and rewarding, especially if the therapist makes use of community resources and does not try to carry the whole therapeutic load himself. He is wise to bring in the help of social agencies, special clinics, psychiatric consultation, the help of the clergyman and the cooperation of the family and the patient's employer, where this is indicated. All of this should be done, as far as possible, with the full coopera-

The long road of rehabilitation for the alcoholic may be punctuated by many crises and the growing field of psycho-pharmacology offers considerable hope for greater success in the care of alcoholics.

GICAL ADJUNCTS in the COMPREHENSIVE nd REHABILITATION of ALCOHOLICS

BY EBBE C. HOFF, M.D.

tion of the patient himself.

Most alcoholics seek help with different degrees of "voluntariness." Motivation for rehabilitation as distinct from simple recovery from a current binge can be strengthened if the therapist stresses to the family and to the patient that therapy, to be successful, must be planned and continuing. Episodic, intermittent treatment based only on carrying the patient through drinking sprees cannot but fail. Alcoholic patients can be unwanted patients in hospitals and doctors' offices partly because the emphasis in treatment has too often been simply upon symptomatic relief. As long as help for the alcoholic is limited to periodic management of his acute alcoholism whether in the hospital, the office or through home visits, with no ongoing rehabilitation program, it is unlikely that much progress will be made.

It is fortunate for the patient if he can be encouraged to seek help before irreversible and serious brain damage has supervened. In these relatively early cases, a short period of hospitalization of a week or two can be quite helpful in initiating a planned program of ongoing treatment, in carrying out a comprehensive diagnostic study and in initiating group and individual therapy. The purpose of such hospitalization as part of a total program of rehabilitation is to carry out a comprehensive diagnostic study and to make a pertinent social and domestic appraisal of the patient and his family. These studies should be conducted within a controlled hospital environment that is suitably supportive and permits the patient to work out with his theraputic team an individualized plan of long-term followup either in an outpatient clinic or with a general practitioner or specialist, utilizing the community resources available and helpful to him. Sometimes hospital care for the alcoholic has to be more prolonged and some alcoholic patients suitably remain in a hospital for a month or more.

Whatever the length of hospitalization and the stated purposes, which vary, it is clear that hospitalization alone cannot do more than initiate rehabilitative

therapy. Whether for a short or long stay, the hospitalized patient ideally finds himself in a carefully planned therapeutic milieu in which he may examine and explore his own psychologic and situational problems and begin to form wholesome relationships and experiment with a new way of life. Although care is rightly given to the management of acute alcoholic intoxication and withdrawal from alcohol, emphasis should also be placed upon long-term rehabilitation from the begining of the outpatient phase of treatment. The approach to the patient should be to avoid excessive, exclusive or disproportionate concentration upon an immediate or recent episode of drinking. Everything should be done to help the patient recover from the current drinking situation as soon as possible and no element of punitiveness should allow the withdrawal period to be any more painful or unpleasant than it need be. Nevertheless, it should be made clear from the start that withdrawal from the alcohol and its immediate effects is not the long-term objective of therapy and that recovery from the immediate alcoholic situation does not necessarily mean that progress has been made in the basic problem.

A primary function of the therapeutic environment in the hospital is to give the patient a significant experience of the reality of his own corporate membership in a body made up of people who are like him and yet are different. Within the group therapy sessions he can experience, often for the first time, the supporting, strengthening power of the whole group of patients and staff and may come to realize that he need never again attempt to function in lonely isolation. The strong organism of the hospital group can represent to him a model upon which

The alcoholic as a sober
have to face and

to build his concept of his membership within his family group and his community. The efforts of a therapeutic team should be directed towards achieving such understanding for the patient as well as for his family members and, wherever the patient and other members of the family are willing and able, the latter should be brought into the therapeutic situation as indicated.

Rehabilitation is a long-term process. While abstinence is an essential daily objective for an alcoholic, this does not mean the end of his problems. Through his sobriety an alcoholic may be helped to recognize that as a sober member of his family and his community he may have to face and deal with more problems than he did while drunk. Formal therapy, therefore, should continue beyond the period of initiation of abstinence and in practice may last for a number of years. Many patients maintain regular contact for many years. Abstinence becomes a sign of recovery and one of its expressions, just as uncontrolled drinking is correctly seen as a symptom of an underlying disorder. The long road of rehabilitation may be far from smooth and may be punctuated by many crises in which an alcoholic slip may be only one variety. As the alcoholic maintains sobriety, it often happens that otherwise subclinical psychologic, domestic and psychosomatic problems come to light. With skilled therapy these disturbances may be abated so that the patient may eventually lead a well-adjusted, healthy life.

It is well known that alcoholics may temporarily or even permanent-

ember of his family and community may
eal with more problems than he did while drunk.

ly transfer their addiction from alcohol to other drugs such as the barbiturates or to other modalities such as food and work. Because of this tendency, the use of pharmacologic adjuncts must be conservative and drugs used only for well-considered indications. Nonetheless, some pharmacologic adjuncts to rehabilitation have been used with beneficial results and the growing field of psychopharmacology offers considerable hope for greater success in the care of alcoholics.

Disulfiram (Antabuse) has been used to enforce motivation for abstinence and has been effective when correctly utilized. This substance given in a daily maintenance dosage of 250 mgs. is usually without any effects by itself. However, if the patient taking disulfiram drinks anything containing alcohol he experiences, within about 10 minutes, symptoms of headache, faintness, prostration, pounding heart and other acute disturbances, mainly referrable to a sudden rapid drop of systemic arterial blood pressure. These symptoms of the disulfiram-alcohol reaction last for about an hour, after which the patient is left in a state of exhaustion. The certainty that he will experience this reaction can serve as a deterrent to alcohol use. Many objectives have underlain the use of disulfiram by alcoholics. It has been thought of as a kind of "pharmacologic fence" built around the patient to prevent him from drinking. The disulfiram has been thought of by the patient as a kind of policeman or at any rate, the long arm of the therapist forbidding alcohol consumption. Some of the psychotic episodes which complicated the earlier use of disulfiram were probably due not to toxic side effects of the chemical itself but to an impossibily high barricade built around the patient to isolate him from alcohol. Such a patient was unable to bear the interdicting force of the drug any more than he could tolerate another person, such as his doctor or his spouse, forbidding him to drink. Experience shows that the use of disulfiram is generally without value if it symbolizes imposition of a state of abstinence by the therapist, the patient's spouse or anyone other than the patient himself. Disulfiram now appears to be effective mainly if the patient himself monitors its use and if he takes it as part of his own daily acceptance of his alcoholism and his personal need for sobriety as a new way of life. Disulfiram should be made available solely for those who take it voluntarily as a means of daily reinforcement of acceptance for the need for sobriety. The patient should be asked to take the daily dose of disulfiram only after he has reaffirmed his own powerlessness over alcohol and decided that he will seek another day of sobriety. This choice means that the patient himself accepts the disulfiram which through the remainder of the 24 hours represents his own motivation. Thus, disulfiram promotes a day-to-day pattern of life punctuated by a moment of decision each day. It has been shown that with patients accepting therapy on a voluntary basis, disulfiram-treated patients show a significantly better clinical outcome over a five-year period than do controls. Disulfiram

tends to be selected by those more highly motivated patients who will continue long-term therapy more faithfully.

Metabolic approaches to the treatment of alcoholics stem from studies suggesting that genetic differences in metabolism may underlie susceptibility to alcoholism. To test this hypothesis, many have reported that rats receiving a marginal diet select high alcohol intake while those who are given high vitamin diets do not. Carefully controlled human studies in which alcoholic patients have been given a polyvitamin formula to supplement the diet over a period of two to three years have failed to show any difference between patients receiving such supplementation and control patients. Statistical analysis of such data suggests that the differences in clinical success (i.e. abstinence and family, job and social adjustment) between the group receiving the supplement and the control group can be explained by random variation. It is evident, however, on a clinical basis that patients receiving high vitamin supplements do feel better and eat better than those in the control group and subsequent experience with these formulas shows that they can be a valuable adjunct in helping outpatients cope with anorexia and excessive fatigue. No patient has ever been shown to have acquired any degree of control over the use of alcohol whether taking vitamins or not. While there are occasional papers in the literature claiming that a few drink moderately without catastrophe, such reports are still suspect and the general conclusion has been that recovery for the alcoholic can only be accomplished through a regimen of total abstinence.

Other metabolic theories of susceptibility to alcoholism include the hypothesis of individual genetic differences in enzyme activity which may affect alcohol metabolism and conceivably play a part in the etiology of alcoholism. Many studies support the hypothesis that alcoholism, while not a clear-cut, single disease entity, may be causally related in part to hormonal imbalance. Although treatment regimens have been based upon therapy with enzymes and hormones, such therapy has not been notably more successful than others.

Chlordiazepoxide (Librium) has been used not only in the management of acute intoxication and withdrawal from alcohol but also as an adjunct to long-term psychotherapy. In the acutely ill patient, chlordiazepoxide, (100 mgs. orally or intramuscularly, followed by 10 to 25 mgs. four times a day by mouth) has been notably effective in calming the agitated patient and in tranquilizing the tremulous alcoholic in the withdrawal period as well as reducing the incidence of delirium tremens. Used for periods of a year or more, chlordiazepoxide in doses of 40 to 100 mgs. a day has been associated with improved follow-up records in clinics and has been effective in abating tension, psychovisceral symptoms, sleeplessness and anxiety. With chlordiazepoxide as an adjunct to psychotherapy there may be greater willingness and ability to explore and face personality problems and life situations. Although the mechanism of the action of this psychopharmacologic agent and others similar to it is not completely understood, it appears from animal studies that chlordiazepoxide, in part at least, acts upon limbic and other higher cerebral autonomic control mechanisms, serving to block cerebrally induced visceral disturbances. Modern stud-

(Continued on page 27)

VOL. 14, NO. 3 INVENTORY SEPTEMBER-OCTOBER, 1964

ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

ALCOHOLISM and the FAMILY

BY R. MARGARET CORK, M.S.W.

The alcoholic and his family are a unity of interacting individuals.

This article, reprinted by permission, originally appeared in the Winter, 1962 issue of *Addictions,* a publication of the Alcoholism and Drug Addiction Research Foundation of Ontario.

MOST people who have known or attempted to help an alcoholic have been concerned to some extent with his family. Until recent years, however, few have seen the alcoholic and his family as a unity of interacting individuals, each of whom reacts to, and is affected by, the behavior and the personality of the other. The tendency was to think of the man and the problem in isolation, instead of in relation to significant people in his life. Only as he is seen more fully in this context, and we deepen our understanding of him as a member of the family, will we develop more effective treatment skills and possibly begin to move into one aspect of prevention, namely, stabilizing the family life for the children of alcoholics.

The alcoholic, like everyone else, began life as a member of the family and much has been suggested about the role his parents played in his developing alcoholism. While there is a fairly widespread agreement that significant early parental relationships, or lack of them, play a decided role in the development of the personality, there is very little to show why some of those who have suffered certain childhood deprivations become alcoholics.

My concern, however, is with the fact that countless clinicians treat patients on the theory that the personality of alcoholics is affected by early parental relationships or lack of them. This may or may not be true but it is the presence of certain characteristics, plus the excessive use of alcohol, which would seem to play a significant part in the disruption or destruction of family life. These characteristics would also seem to take on significance in the rehabilitation of the family after the drinking is controlled.

We know from various studies so far that there is no one personality type amongst those who become alcoholics; it has been generally accepted, however, that many alcoholics do tend to have the following characteristics which would seem to have particular significance for our consideration of the alcoholic as a family member:

—a difficulty in accepting appropriate responsibility

—excessive dependency needs, which often show up as a strong assertion of independency

—a lack of self-discipline often seen in the impulsivity and indulgence of self or others
—a preoccupation with self
—a negative attitude towards authority with consequent repressed or acted out hostility
—a sense of inadequacy in certain vital areas of life
—an unrealistic approach to problems
—limited interests
—shallow or superficial interpersonal relationships which make it difficult to communicate or share with another individual at a mature level.

As we see the alcoholic after the alcoholism has become more severe, these characteristics are often accentuated and may be a source of considerable resentment to the spouse, often greater than the resentment towards the drinking, except possibly in its worst moments. They are frequently the source of considerable or constant marital disharmony before or after the alcoholism develops, depending on such basic factors as the original stability in the marriage, the disturbance in the marital partner, the reaction of the wife to the excessive drinking and consequent social and emotional problems.

As has already been mentioned, the alcoholic does not exist in a vacuum. His personality and his behavior affect those closest to him, particularly his wife. Because of the interaction between them, each one helps to keep alive or to accentuate the other's problem. What does the wife contribute to the family problems and/or the on-going excessive drinking? She is often seen as tragic, brave, and patient, a helpless victim of circumstances. The clergyman, physician and friends of the family counsel the wife of an alcoholic as if she is a stable, capable and non-involved person. This is not true, according to studies made to date. She is not the innocent bystander in a drama of mistreatment and misery. Segall says that she is "equally responsible for the making of the marriage and the participant in the creation of all the pain and unhappiness that follows."

The husband of an alcoholic woman has not been studied to any great extent. However, he has been found by clinicians to be generally less patient and less accepting than the wife, less able to use help, and more likely to terminate the marriage. Fox believes this is due in great part to the wife's capacity to mother, once she senses her husband's illness, to the greater permissiveness in our culture to drinking amongst males, and to the wife's financial dependence or difficulties inherent in raising children alone.

I would now like to take a closer look at the families from which the largest group of alcoholics come. This is the family which has had some years of relative stability and meaningful interpersonal relationships, the family in which the father, over a number of years, has been a contributing member, at least financially, and/or socially and emotionally. Whatever personality difficulties and conflicts there may have been in either partner have been accepted or tolerated, or the resentment around such has been held at bay, or sublimated in various ways.

In the eyes of the community, or to those of us fairly close to an alcoholic and his family, it often looks as though the upset to family life occurs just around the recurrent drinking bouts. In some few cases where family stability has been great, it may be so, and with the control of the drinking, family life

assumes its former adequacy. But I believe that a very large number of families that are faced with alcoholism already have certain underlying stresses and tensions, certain personality differences and strained patterns of interacting which they are able to handle, but which, with the continued drinking, play their own interacting part in the disruption or disorganization of family life.

What are the feelings, attitudes and ways of reacting which would seem to be common to most or many families as they live through the experience of having an alcoholic member? I list these not in any order of occurrence or of importance. There is in most families at some time the need to hide or deny the problem, a tendency to blame the problem on certain external factors and an attempt to resolve the problems by eliminating or avoiding these; an extension of this is to blame the problem (or accept blame for it) on certain family members.

Fears Emerge

Fears of all kinds may show themselves, ranging through fear of what neighbors will say or think, and fear of financial deprivation to the fear of whether one is really losing one's mind. Many families go through the experience of protecting the sick member, not so much in a need to deny the problem or to help him, and both can happen, but rather to save themselves from the consequences of loss of job and/or jail sentence. Most wives go through a varying series of attempts to cure him by the oft-mentioned methods of nagging, babying, belittling, isolation, taking over, and submitting to his every demand, including abuse.

In most families there are frequent and constant quarrels and differences that may never be resolved and hurts that never heal. The nonalcoholic partner often lines up the children against the sick parent, or so identifies with his illness that the whole family life and the individual behavior of its members is geared to keeping the father sober, or coping with the consequences of his last bout. Some wives leave home time and again, usually not because they want to, but to punish or show their independence. Some find a way of going on without the alcoholic partner, almost as if he weren't there, even though they are still under the same roof. Many mothers take on a kind of separation by over-identifying with the children and their interests and needs, to the exclusion of the alcoholic.

There are several general implications of all this on family life if continued over a period of years:

—in relative degree the roles of all family members may become distorted or lost sight of.

—individual members may react and interreact not only to the hurt engendered by the alcoholism, but the normal pains and frustrations of life are never understood and the normal reactions of family members to one another are not given consideration.

—every family member may feel relatively misunderstood without opportunity or psychic energy to work this through.

—the family as a unit, and individually, may become isolated from normal social contacts and experiences. Individual members are thrown back more and more on one another, with less and less chance of these relationships being satisfying.

—meaningful family goals may be lost sight of, and standards and values that were there before

no longer prevail.

—the wife and mother may be so absorbed in controlling the drinking or curing the alcoholism that she has little energy or thought to give to the children's emotional development and problems beyond that of day-to-day care.

—personality differences and inadequacies in both marital partners may become accentuated, which, in turn, interact on the need to increase the consumption of alcohol. This sets in motion new or increased reaction or interaction between family members and the oft-quoted vicious circle is observed.

The children in the family of the alcoholic are of such primary concern to most of us and have all too long been left unstudied, that I would like to comment briefly on some of the particular implications for them of the kind of family living just described. An article on some observations of the normal child states that the normal pre-adolescent gains within the family such things as a well-developed time perspective; a sense of trust in the future; a sense of objectivity; ability to delay; tolerance for frustration; realistic non-magical perception of cause and effect; initiative and capacity for taking responsibility; an ability to find answers to problems and confidence in one's ability to meet environmental challenges; and a sense of self-esteem.

Turn, then, to the child who has lived some or a good portion of his life within a family experiencing alcoholism in one of its members, and consider the chances he may have to attain or sustain such normal development. In the alcoholic's family, we see the child pulled many different ways by the parents' inconsistent attitudes toward one another

The children in the famil

and to other family members, by the amount of hate the parents express and demonstrate and the amount of hurt each has received. The child is conflicted by the mother's taking over the father's role, as well as her own (or to the detriment of her own). He cannot help but be torn and confused by the different feelings the alcoholic has for him when drunk or when sober, or influenced by the particular hostility directed towards him by one parent, if he resembles the other parent. This child frequently has too much responsibility without understanding, or is indulged by one or both parents in different ways. He is torn by his loyalty to family and what the community feels about his father.

The child experiencing some of these conflicts in feelings cannot help but react and interact with his parents and siblings in a far from growth-producing way. He obviously suffers in a rleative degree from lack of strong parental figures on which to pattern himself, from conflict around these figures or from over-identification with one or the other parent. As already mentioned, he may have difficulty in finding his own identity, depending on what age he is when the alcoholism occurs, and certainly he may have a more than usual problem in attaining and/or sustaining his own appropriate role in the family. More specifically, he may be unsure of what is expected of him and what he can expect of others. We find that his needs are often met on the basis of his own personality make-up. Many such children have difficulty accepting appropriate responsibilities or in disciplining themselves. Some become

the alcoholic have all too long been left unstudied.

fearful of expressing themselves or their feelings, or in their anxiety act these out with considerable aggressiveness.

The general implication in all this is that the child has limited opportunity to grow and develop normally and/or may be severely damaged by such an experience. The miracle is that he survives at all and one questions why so many survive as well as they do. To what degree there is hidden damage which will not come to light until later is an urgent matter for further research.

This, then, brings us to the matter of treatment. Treatment must be geared not only to the alcoholic, but to the wife, and directly or indirectly to the children. Such treatment is directed toward getting a better understanding of the emotional factors underlying the alcoholism and the family disorganization, of the interpersonal relationships and interaction of family members. Such therapy for the family is indicated not only because of the interaction and interrelatedness of all who are close to the alcoholic, but because it emphasizes the marriage, because there is more chance for both parents to feel less guilty and more responsible for what happened and for what has to happen to rectify the situation. Such treatment brings a strong element of hope to those who want to find family stability for the first time, or find again or even improve on the family unity they once had.

Whether a wife and husband seek help together of their own accord or individually are sent by some interested party, they both come with many fears, fears of the interview experience itself (for this means facing another person who represents authority and there has often been lifelong difficulty with such figures), fears of what they may be involved in, fears of what may be expected of them and of how much it is safe to tell.

Both partners have many mixed feelings about admitting the fact of alcoholism, the marital troubles, and their inability to work things out for themselves. Sometimes both seek tangible answers to the problem, but the wife often has greater difficulty than the alcoholic partner in accepting that cessation of the drinking will not solve all the problems. Often her request for help is in terms of "How can I cure him?" If we fall into the trap of assisting her in this, rather than helping her as an individual to face and work on her own neurotic problems, we do little of lasting value, and she breaks contact as readily as the alcoholic who is not ready to stop drinking.

Obviously, successful treatment of the alcoholic and his family is a large order. The undertaking of it, if it is to mean more than just control of the drinking problem, may seem overwhelming to most individual therapists or counselors. Experience with the clinical multidiscipline approach leads me to suggest the development of community teams made up of representatives from the different helping professions working together.

Such a team calls for greater understanding of past failures to rehabilitate the alcoholic. It means a conscious effort on the part of all therapists to stop feeling threatened by one another; to gain a real appreciation of the particular contribu-

tion of others; to accept a degree of overlapping; to lose some of the possessiveness and competition to cure the alcoholic. Above all, it means that the alcoholic must be freed to relate to many people without being allowed to play one therapist against the other.

While many professional groups and individuals who are in touch with the alcoholic and his family can play a vital part, four of the professional groups whom I feel have a significant role to play in treatment and prevention in this field of alcoholism are doctors, the clergy, nurses and social workers. A community team made up of individual therapists from these disciplines should not only be able to share appropriately and realistically in rehabilitating the alcoholic and his family, but each must assume a responsibility for interpreting the illness or the ill person to others in the community.

I do not say that community teams are *the* solution to the problems presented by this illness. I do believe, however, that through such an approach, larger segments of our communities might more readily change their attitudes and more quickly lose their fears; that within an atmosphere of community acceptance, thousands of alcoholics and their families not yet getting help might find the courage to acknowledge their illness; that above all, the helping professions might begin to lose some of their individual sense of apathy, discouragement and isolation, and might individually revitalize and/or revamp their time-tried treatment skills and together, as we haven't been able to do too successfully alone, to find the way to combat an illness which I believe is seriously affecting countless families and the individuals who comprise them.

PERFECTION & THE ALCOHOLIC

CONTINUED FROM PAGE 3

share.

Few non-alcoholics would go to work with the kind of hangover that some alcoholics endure. The former would be too sick to move. But the alcoholic is so afraid that his "weakness" will be detected that he makes a superhuman effort to get up, shave, dress, and get to the job.

A woman alcoholic was recommended for employment as public relations director of a large candy manufacturing company. True to the alcoholic pattern, she went on an epic binge on the eve of the interview and woke up with a hangover that saturated every fibre of her tortured body. She steadied the shakes with "the hair of the dog that bit her", mobilized a few fragments of energy and sallied forth.

The employment manager suggested that she tour the plant in which she would be working and the tour included several stopovers at vats of steaming melted chocolate.

Years later the memory of this experience tinged her face with green as she told it. "Have you ever had a hangover," she asked with a sickly grin, "and had to spend the morning looking at and smelling vats of chocolate?" She didn't take the job.

As we have indicated, this imperative need to prove themselves can be an obstacle to the treatment of alcoholics. If they fail, they return to drinking. Then, if alcohol is taken away, they are deprived of their major defense. This means that the therapist must move quickly to help them find satisfactions to replace those provided by the drinking. It means giving the patients a sound basis for believing in themselves as worthwhile human beings. It means helping them to find something to live for that is within their grasp. It means persuading them that this is possible short of perfection.

PHARMACOLOGICAL ADJUNCTS

CONTINUED FROM PAGE 20

ies of the limbic system and related higher cortical levels have indicated complex mechanisms for the control of visceral functions by the autonomic nervous system. Stimulation of specified isocortical, paleocortical and other higher cerebral areas evokes alterations of systemic blood pressure, changes in intracardiac dynamics, modifications of peripheral circulation as well as functional and vascular changes in the kidney, gut and other organs, including the heart.

It appears that these cerebral autonomic control mechanisms may also be related to forms of behavior and emotional activity. Disturbances of these higher cerebral mechanisms may be a part of the underlying etiological disorders in the alcoholic. Therefore, neuropsychologic agents which can be shown to protect the autonomic nervous system from higher cerebral over-response to stress may have a value in the long-term rehabilitation of alcoholics. Alcohol itself can be shown to be an imperfect attenuator of centrally generated autonomic disturbances and, in fact, under some circumstances may act to exacerbate the cortical autonomic responses. Alcohol thus appears to be a defective tranquilizing agent, especially for some individuals and under certain circumstances. On the other hand, chlordiazepoxide and certain other modern tranquilizing agents may protect the viscera from harmful cerebral autonomic dysfunction. Thus, a mechanism of action of such substances may be to reduce cortical autonomic overactivity and so facilitate the beneficial effects of psychotherapy and render the patient more available to psychotherapy.

THE LONELY ROAD

CONTINUED FROM PAGE 11

At this point he has been described as 'infantile, regressed, neurotic, selfish, irresponsible. He appears to be apprehensive, anxious, jittery, bleary-eyed, sloppy, untruthful, undependable; suggestible and easily swayed one moment; perverse, belligerent, and stubborn the next. When his drinking has reached the point where he has the 'shakes' he is a pathetic and perspiring mass of tremors and jerks, with a sullen and painful expression, with an untidyness and dissipation that are characteristic.'

Skid Road or the mental hospital may be the destination of many who reach this stage. But comparatively few alcoholics do reach this late stage; most do not live long enough.

At one time it was thought, and to this day there are some who still think, that the alcoholic must 'hit low bottom' before he is 'ready' for recovery. They tell us that in the old days of AA a man who had not gone completely under, who still held on to some shreds of respectability, was told to go away and do some more drinking because 'he hadn't suffered enough.' We know now that this view of the recovery potential in alcoholism is defeatist, and unfounded; it may lead to tragedy.

Many late-stage alcoholics make remarkable recoveries, but recovery can commence at any point provided that the alcoholic recognizes his ailment and his inability to recover by his own unaided efforts.

Help is his for the asking, as near as the telephone. Alcoholics Anonymous, professional treatment clinics, and other community resources are readily available. There is a 'new deal' for alcoholics, through increasing public awareness, knowledge, and understanding.

What's brewing?

A feature designed to help you keep posted on developments in the field of alcoholism.

NOTICE

Quite a few out-of-state readers of **Inventory** who recently sent in postal cards stating that they wished to continue receiving the magazine neglected to include their names and addresses. Those in this group will not receive the September-October issue of **Inventory**. They may be reinstated on the mailing list by writing the Circulation Manager, P. O. Box 9494, Raleigh, N. C. and including their names and addresses.

RESEARCH GRANT AWARDED: The Division of Alcohol Problems and General Welfare of the Board of Christian Social Concerns of the Methodist Church announced recently that a research grant for 1964-65 has been awarded to Charles Norman Alexander, Jr., Ph.D. candidate in the Department of Sociology at the University of North Carolina. Mr. Alexander's project is enitled "A Longitudinal Study of Social Influences on Drinking Behavior." This marks the third year in which these research grants have been awarded to deserving individuals throughout the United States.

CAMP CAROLINE, N. C.: The sixth annual Alcoholics Anonymous Family Retreat was held recently at Camp Caroline. Members of AA and their immediate families gathered together to enjoy the good fellowship, recreation and inspiration that is typical of AA retreats. Those attending were privileged to hear Judge John D. Larkins, Jr. of Trenton, N. C.

PRAGUE, CZECHOSLOVAKIA: Czechoslovakia has a new law ordering the confirmed drinker to consult a physician when his condition endangers the state or interferes with his work or family life. In some instances, the alcoholic may be forced to undergo institutional care if the physician believes it necessary. All Czech traffic policemen carry vials containing a chemical reagent through which any driver suspected of drinking is required to blow. If the material changes in color, the individual is taken to the police station for a more accurate test.

ALCOHOL AND BARBITURATES: A study recently reported in **Time** magazine indicates the possibility that an ordinary sedative dose of a barbiturate may combine with an intoxicating amount of alcohol to leave behind a lethal dose of nerve-depressant alcohol. Biochemist Jack E. Wallace and Elmer V. Dahl, M.D., of Lackland Air Force Base in Texas, who conducted the study, found that the use of barbiturates hinders the normal breakdown process of the body in handling alcohol, thus leaving a lot of it in the system. Alcohol has a severe depressing effect on some primitive nerves, including the center regulating breathing.

RALEIGH, N. C.: The dates for several Summer Schools of Alcohol Studies in 1965 were announced recently by Dr. Norbert L. Kelly, director of the Education Division, N. C. Department of Mental Health. The East Carolina College school will be held June 8-18 and the sessions at the University of North Carolina will take place June 20-25.

NEW BRUNSWICK, N. J.: Currently underway at the Rutgers Center of Alcohol Studies is a semantic study on alcohol terminology entitled "Alcoholism Nomenclature and Classification." The study is being made possible by the extension of a grant of $20,302 awarded by the United States Public Health Service when the Center was located at Yale University. Originally sponsored by the North American Association of Alcoholism Programs, the grant will finance the completion of a dictionary of words frequently used in the field of alcohol studies. Mark Keller, editor of the **Quarterly Journal of Studies on Alcohol,** is director of the project which is expected to be completed in the Spring of 1965.

WASHINGTON, D. C.: The federal government is urging state public welfare departments to provide a wide range of social services to help prevent alcoholism and minimize its damaging effects on families. Welfare Commissioner Ellen Winston has informed state welfare directors that the federal government may now pay up to 75 percent of the cost of furnishing rehabilitative and preventive services to families and individuals.

PORTLAND, OREGON: The annual meeting of the North American Association of Alcoholism Programs will be held at the Park Sheraton Hotel in Portland September 27-October 1. The meeting will open with a medical symposium at the University of Oregon Medical School. Ira B. Pauly, M.D., of the department of psychiatry at the University of Oregon School of Medicine, will chair the symposium which will include a demonstration on interviewing techniques showing how physicians may identify and evaluate alcoholism.

Among the participants on the program are David Pittman, Ph.D., secretary of the NAAAP, and chairman of the social science institute at Washington University, St. Louis, Missouri, who will deliver the keynote address; and James R. MacKay of New Hampshire who will discuss teen-age drinking.

WASHINGTON, D. C.: Gus Hewlett, former Director of Information and Education with the Alabama Commission on Alcoholism, has been named Executive Secretary of the North American Association of Alcoholism Programs. He assumed his new duties in Washington on September 1.

NEW BRUNSWICK, N. J.: The more education an American has, the more apt he is to drink, says Robert W. Jones, assistant director of the Center of Alcohol Studies at Rutgers University. Well over half of the people with only an elementary education drink, he said. Approximately 70 percent of the people with high school educations drink and the percentage is greater among college graduates, Jones said. He also pointed out that most American drinkers start at the age of 16 or 17.

CIRRHOSIS OF THE LIVER: Deaths from cirrhosis of the liver have nearly doubled in the United States in the last thirty years among men and women aged 35 to 40, according to the U. S. Public Health Service. One of the five principal causes of death in this age group, cirrhosis of the liver is caused primarily by consumption of alcoholic beverages, although it is known to occur in occasional drinkers and in total abstainers.

CONTINUED FROM PAGE 15

it his drinking is a habitual part of his life and he becomes its slave. Don't ask me what the predisposition is. I can give you some theories, I can give you some facts, but I cannot give you any definitive answers to this question.

We ask a lot when we ask an alcoholic to stop drinking. We make this demand, this almost impossible demand, and sometimes we have to make it, though in some instances we may not have the right to do so because of what I'm going to say in a minute. Unfortunately, when I make it sometimes, I am forced to commit someone to a mental hospital. I don't know which is better. At least I do have the alternative of giving them tranquilizing drugs which in a general way do precisely the same thing to nervous tissue that alcohol does.

Now, we have already discussed some of the blessings of alcohol and you are not going to take away pleasure and blessings and all of these virtues without a fight, and I think you'd better know what you're doing when you do.

I have said that alcohol has been mankind's psychological blessing since the inception of its existence. I am now about to say again that alcohol has been man's physiological curse, as well.

The psychological blessings of alcohol are bought only at the expense of functioning nervous tissue in the brain and spinal and peripheral nerves. Now let me say that again. The psychological blessings of the use of alcohol are bought at the expense of the nervous system by interfering with the normal physiology of the nerve cells of the brain —an organ which is a most sensitively-tuned, finely-organized, delicately-balanced bit of human machinery. It is unlike other tissue in the body in its antomical function and structure. Its powers of regeneration, for example, are quite limited.

Now, let me draw some of the conclusions with you that I have drawn from my own experience.

All of you are probably familiar with what you see when you look at an acute alcoholic, someone who is acutely intoxicated. You've had that experience, I trust. Some of you have had the personal experience. Others of you as physicians have seen one, but I wonder if you really see what you are looking at.

The Acute Alcoholic

What I see when I look at an acute alcoholic is an individual who repeats himself. He will say the same thing over and over and over and over again. He'll tell you the same thing over and over again until you say, "Ah, I know it, you told me before," but it doesn't make any difference. He tells you all over again, and it's usually, "I'm not drunk, I'm fine, I can do all right, I'm okay, Let me go," and he gets up and falls flat on his face.

I also know that if you talk to an acute alcoholic you may say the same thing again and again and again, and it doesn't seem to sink in. It just doesn't get there. For some reason he cannot grasp what you are trying to convey.

If you ask the acute alcoholic what's been going on, it is usually said that he will lie like a trooper. He'll give you a story—some kind of story, it doesn't make any difference what kind—but when you begin to check the facts, as the legal people will, they just are not the facts.

The other thing is that there is nobody who is as deluded about what he can achieve and accomplish as

someone with a few drinks in him. I had some bitter personal experience with a guy who thought he could fly an airplane when he had about two drinks in him. He tore my ship up, and it's hard for me to forgive him but I knew he was intoxicated. He never even got it off the ground. In fact, he wrapped the wing around the hangar.

The description of an acute alcoholic that I have given you is an individual who cannot remember. He cannot learn. He will give you a story. He will supply information which is not accurate, he'll make it up if necessary, and he can do *anything,* absolutely anything.

Now, I'll give you a short case history of a fellow who came to the Center. He was forty-five years old and he had been sober for fourteen years after which he went on two binges and came to the Center twice. The second time he came, he was a lot worse off than the first time. He was talking to Dr. Hopkins, the general practitioner who is with me now, in his office which is about ten feet down the hall from my office. I heard Dr. Hopkins say, "I can't answer that, you'll have to ask the boss." This fellow, after having been off alcohol for a good two weeks, could not, in the course of that little walk from Dr. Hopkins' office to my office, recall my name (which was announced to him because I heard it) or remember Dr. Hopkins' name. He supplied us with names, though, although they were not even phonetically related to either Desrosiers or Hopkins. He gave us names and he wanted to know if he could go home.

I was able to make a tragic diagnosis on this man at that point. You know what the diagnosis is. He displayed the four symptoms of Korsakoff psychosis, which is an irreversible, organic, deteriorative disease: recent memory loss, inability to learn, confabulation, and delusional thinking.

I have now completed my description of the end result of chronic alcoholism. What you see in the acute alcoholic is the Korsakoff he eventually becomes. It may take ten years, it may take fifteen years, it may take twenty years, or it may take a lot longer, depending upon how heavily he drinks. But the old biogenetic principle that ontogeny recapitulates phylogeny still holds; in other words, what goes before repeatedly eventually becomes so. I hate to make that diagnosis, but I have a feeling that this is what one sees in the progressive discontrol, to use Menninger's term, of the developing, chronic deteriorative disease of alcoholism. It merits serious attention.

Protein Denaturant

I could go on. This is a subject which fascinates me, but I will close with one thing I heard yesterday that really shook me up. I listened to a group of biogeneticists in Raleigh talking about the influence of emotions on possible permanent genetic changes that occur not on the outside of a cell, but in the stuff of life itself, in the patterning of the nucleic acids, which are all proteins, and its eventual transmission to progeny. It scared me to death because alcohol is one of the most potent protein denaturants there is. We "fix" tissue with it.

It scares me, too, when I recall a statistic from France which points out that the children of active alcoholic parents have a rate of about two and one-half times the general population for producing mentally retarded offspring. I shudder.

Now, you stand where I stand. Hopefully, you know a little bit more about what we are up against.

DIRECTORY OF OUTPATIENT FACILITIES
for
ALCOHOLICS AND/OR THEIR FAMILIES

Competent Help Is Available At The Local Level

Key to Facility and its Service

***Local Alcoholism Programs**
for
(Alcoholics and Their Families)
—Education
—Information
—Referral

†Mental Health Facilities
for
(Alcoholics and Their Families)
—Outpatient Treatment Services

‡Aftercare or Outpatient Clinics
for
(Alcoholics who have been patients of the N. C. Mental Hospital System)
—Outpatient Treatment Services

ASHEVILLE—

**Educational Division, Board of Alcohol Control;* Parkway Office Building; Phone rector; Parkway Office Building; Phone ALpine 3-7567.

†*Mental Health Center of Western North Carolina, Inc.;* 415 City Hall; Phone: ALpine 4-2311.

BURLINGTON—

**Alamance County Council on Alcoholism;* Margaret Brothers, Executive Director; Room 802, N. C. National Bank Building; Phone: 228-7053.

‡*Outpatient Clinic;* Alamance County Hospital; Hours: Wed., 9:00 a.m.-4:00 p.m.

BUTNER—

‡*Aftercare Clinic;* John Umstead Hospital; Hours: Mon.-Fri., 9:00 a.m.-4:00 p.m.

CHAPEL HILL—

†*Alcoholism Clinic of the Psychiatric Outpatient Service;* N. C. Memorial Hospital; Phone: 942-4131, Ext. 336.

**Orange County Council on Alcoholism;* Dr. D. D. Carroll, Director; 102 Laurel Hill Rd.

CHARLOTTE—

**Charlotte Council on Alcoholism;* Rev. Joseph Kellermann, Director; 1125 E. Morehead St.; Phone: FRanklin 5-5521.

‡*Mecklenburg Aftercare Clinic;* 1200 Blythe Blvd.; Hours: Mon.-Fri., 8:00 a.m.-5:00 p.m.

†*Mental Health Center of Charlotte and Mecklenburg County, Inc.;* 1200 Blythe Blvd.; Phone: FRanklin 5-8861.

CONCORD—

†*Cabarrus County Health Department;* Phone: STate 2-4121.

DURHAM—

‡*Aftercare Clinic;* Watts Hospital; Hours: Tues. and Fri., 2:00-5:00 p.m.

**Durham Council on Alcoholism;* Mrs. Olga Davis, Executive Director; 602 Snow Bldg.; Phone: 682-5227.

FAYETTEVILLE—

†*Cumberland County Guidance Center;* Cape Fear Valley Hospital; Phone: HUdson 4-8123.

GASTONIA—

†*Gaston County Health Department;* Phone: UNiversity 4-4331.

GOLDSBORO—

‡*Outpatient Clinic;* Cherry Hospital; Hours: Tues. and Fri., 10:00 a.m.-12:00 noon. Thurs., 2:00-4:00 p.m.

**Wayne Council on Alcoholism;* A. T. Griffin, Jr., Executive Director; P. O. Box 1320; Phone: 734-0541.

GREENSBORO—

**Greensboro Council on Alcoholism;* Worth Williams, Executive Director; 216 W. Market St., Room 206 Irvin Arcade; Phone 275-6471.

†*Guilford County Mental Health Center;* 300 E. Northwood St.; Phone: BRoadway 3-9426.

†*Family Service Agency;* 1301 N. Elm St.

‡*Outpatient Clinic;* 300 E. Northwood St.; Hours: Mon. and Thurs., 5:00-10:00 p.m.

GREENVILLE—

†*Pitt County Mental Health Clinic;* Pitt County Health Department, P. O. Box 584; Phone: PLaza 2-7151.

HENDERSON—

**Vance County Program on Alcoholism;* Dr. J. N. Needham, Director; 2035 Raleigh Rd.; Phone: GEneva 8-4702.

HIGH POINT—

†*Guilford County Mental Health Center;* 936 Mountlieu Ave.; Phone 888-9929.

JAMESTOWN—

**Alcohol Education Center;* Ben Garner, Director; P. O. Box 348; Phone: 883-2794.

LAURINBURG—

**Scotland County Citizens Committee on Alcoholism;* M. L. Walters, Executive Secretary; 308 State Bank Bldg.; Phone: 276-2209.

MORGANTON—

‡*Aftercare Clinic;* Broughton Hospital; Hours: Mon.-Fri., 2:00-4:00 p.m.

NEW BERN—

**Craven County Council on Alcoholism;* Gray Wheeler, Executive Secretary; 411 Craven St., P. O. Box 1466; Phone: 637-5719.

*†*Psychiatric Social Service,* Craven County Hospital; Phone: 638-5173, Ext. 294; Hours: Mon.-Fri., 9:00 a.m.-5:00 p.m.

NEWTON—

**Educational Division, Catawba County ABC Board;* Rev. R. P. Sieving, Director; 130 Pinehurst Lane; Phone: INgersoll 4-3400.

PINEHURST—

Sandhills Mental Health Clinic; Box 1098; Phone: 295-5661.

RALEIGH—

‡*Aftercare Clinic;* Dorothea Dix Hospital, S. Boylan Ave.; Phone: TEmple 2-7581; Hours: Mon.-Fri., 1:00-4:00 p.m.

†*Outpatient Clinic of the Mental Health Center of Raleigh and Wake County, Inc.;* Wake Memorial Hospital; Phone 834-6484; Hours: Mon.-Fri.; 8:30 a.m.-5:30 p.m.

SALISBURY—

**Educational Division, Rowan County ABC Board;* Peter Cooper, Director; P. O. Box 114; Phone: 633-1641.

†*Rowan County Mental Health Clinic;* Community Bldg., Main and Council Sts.; Phone: MElrose 3-3616.

SANFORD—

†*Mental Health Clinic of Sanford and Lee County, Inc.;* 106 W. Main St.; P. O. Box 2428; Phone: 775-4129 or 755-4130.

SHELBY—

†*Cleveland County Mental Health Clinic;* 101 Brookhill Rd.; Phone: 482-3801.

SOUTHERN PINES—

**Moore County Alcoholic Education Committee;* Rev. Martin Caldwell, Director; P. O. Box 1098; Phone: OXford 2-3171.

WADESBORO—

**Educational Division, Board of Alcohol Control;* Robert M. Kendall, Director; 125 W. Wade St.; P. O. Box 29; Phone: 694-2711.

WILMINGTON—

†*Mental Health Center of Wilmington and New Hanover County;* 920 S. 17th St.; Phone: 763-7342.

**New Hanover County Council on Alcoholism;* Mrs. Margaret Davis, Executive Secretary; 211 N. Second St.; Phone: 763-7732.

WILSON—

‡*Aftercare Clinic;* Encas Station; Hours: Mon.-Fri., 8:00 a.m.-5:00 p.m.

†*Wilson County Mental Health Clinic;* Encas Rural Station; Phone: 237-2239.

WINSTON-SALEM—

*†*Alcoholism Program of Forsyth County;* Marshall C. Abee, Executive Director; 802 O'Hanlon Bldg., 105 W. 4th St.; Phone: PArk 5-5359.

WISE—

**Warren County Program on Alcoholism;* Rev. A. T. Ayscue, Director; Box 100; Phone: 257-4538.

YADKINVILLE—

**Alcoholism Information Center;* Rev. James A. Haliburton, Director; Yadkin County Courthouse.

ARP EDUCATION AND INFORMATION SERVICES

INVENTORY—bi-monthly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from State Health Department. Please request films as far in advance as possible and state second and third choices.

The ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—Family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

The Lonesome Road—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.

Anyone You Know?—radio drama of the steps to alcoholism, to voluntary treatment, to rehabilitation, in 15-minute records.

Library Books—Books on alcoholism are available from the North Carolina State Library through local libraries to residents of North Carolina. To obtain any of the books listed in the March-April issue of **Inventory**, go to your community library and make the request.

Staff Speakers—members of the Raleigh and Butner staffs are available for speeches before civic and professional groups.

Book Loan Service—kits containing reference books and pamphlets on alcoholism. Available to teachers from the Education Division, N. C. Department of Mental Health, Raleigh.

Consultant Service for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

Education Division, N. C. Department of Mental Health
P. O. Box 9494
Raleigh, N. C.

Entered as Second-Class Matter at the Post Office, Raleigh, N. C., under the authority of the Act of August 24, 1912.